State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ B. WING _____	C 02/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	**934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00158002. The complaint was unsubstantiated.	I 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ B. WING _____	R-C 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	**934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{I 000}	Initial Comments. A follow-up to the complaint investigation of 11/29/16 was conducted. No deficiencies were cited.	{I 000}		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11L005	A. BUILDING _____ B. WING _____	R-C 02/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	**934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306**

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{N 000}	Initial Comments A follow-up to the complaint investigation of 11/29/16 was conducted. No deficiencies were cited.	{N 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

approved 4/22/15 MT

PRINTED: 04/06/2015
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

HEALTHCARE FACILITY REGULATION DIVISION
APR 22 2015
RECEIVED 04/03/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11L005	A. BUILDING _____ B. WING _____	

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

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N 000	Initial Comments A recertification survey and follow-up to a complaint investigation (GA00144467) conducted on 12/3/2014 was done on 4/2/15 and the Laurel Heights (PRFT) was in substantial compliance with 42 CFR Part 483, Sub Part G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Twenty One, the following deficiencies were otherwise cited:	N 000		
N 143	483.358(d) ORDERS FOR USE OF RESTRAINT OR SECLUSION If the order for restraint or seclusion is verbal, the verbal order must be received by a registered nurse or other licensed staff such as a licensed practical nurse, while the emergency safety intervention is being initiated by staff or immediately after the emergency safety situation ends. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must verify the verbal order in a signed written form in the resident's record. The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must be available to staff for consultation, at least by telephone, throughout the period of the emergency safety intervention. This ELEMENT is not met as evidenced by: Based on record review, observation, and interview the facility failed to insure that the verbal orders were being signed by the physician within twenty-four (24) hours for six (6) of ten (10) sampled patients. Findings include:	N 143	Corrective Action: Medical Director met with all physicians on April 21, 2015 and directed them to verify seclusion/ restraint orders within 24 hours. A separate seclusion/ restraint order form has been created and will be presented to GOB for approval on April 30, 2015. The order form will go directly to the physician for signature, no longer requiring the Dr. to review every patient record to verify orders. Once approved, the form will be submitted for printing and implemented upon receipt. Target Date of May 30, 2015. Education: Director of Performance Improvement will meet with current physicians individually to review new process; and will add instruction and competency to new physician orientation by May 30, 2015. Monitoring: The Risk Manager will complete weekly random audits of seclusion/ restraint order forms and report to Medical Director any instances of non-compliance. Medical Records will complete a monthly audit of seclusion/ restraint forms and report	4/21/15 5/30/15 5/30/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Steven M Cleo, CEO — TITLE: 4/21/2015 — (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11L005	A. BUILDING _____ B. WING _____	04/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

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N 143	Continued From page 1 Record review revealed the following: 1. Record review for patient #1 revealed six (6) order not signed timely. 2. Record review for patient #4 revealed four (4) orders not signed timely. 3. Record review for patient #5 revealed one (1) order not signed timely. 4. Record review for patient #6 revealed four (4) orders not signed timely. 5. Record review for patient #7 revealed ten (10) orders not signed timely. 6. Record review for patient #9 revealed one (1) order not signed timely. Interview on 4-1-2015 with Risk manager confirmed these findings. She states that the physician that signed each order noted is at the facility every day. Review of the policy titled " Seclusion and Physical Hold Restraint " states in part " ...physician ' s written order is entered into the clinical record within 24 hours or as soon as possible ... "	N 143	to the PI Committee. Goal of 100% compliance with audits to begin in June. Responsible Persons: Medical Director, Risk Manager, Director of Health Information	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ APR 22 2015 B. WING _____ RECEIVED	04/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

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I 000	Initial Comments. A relicensure survey was completed on 4/2/15 and Laurel Heithgs (RMHF) was in substantial compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth. The following deficiencies were cited:	I 000		
I 763 SS=D	111-8-68-.07(5) Services- Nutrition. Nutrition. Food services must comply with the Rules and Regulations for Food Service, Chapter 290-5-14. There must be a provision for planning and preparation of special diets as needed. Menus shall be evaluated by a consultant dietitian relative to nutritional adequacy at least monthly, with observation of food intake and changes seen in the patient. This RULE is not met as evidenced by: Based on review of facility food temperature log, policies and procedures and interview, the facility failed to ensure that foods served to its patients were monitored for appropriate temperature in a manner to protect them from potential contagion in thirteen (13) out of twenty-seven (27) meals served. Findings include: Tour of the facility's kitchen at 9:50 a.m. on 4/01/2015 with the facility's Dietary Manager and review of food temperature logs revealed that food service personnel failed to record guide line temperatures for food to be served to residents for four (4) breakfasts, two (2) lunches and seven (7) dinners between 3/18/2015 and 3/26/2015.	I 763	Corrective Action: The Director of Food Services held a training with all dietary staff on April 1, 2015 reviewing the policy 'Infection Control Dietary Services: Food Preparation, Service and Cleanliness'. As an additional check, Education: The Director of Food Services and Dietitian will develop and educate dietary staff to annual competencies that will include review and acknowledgment of policies and procedures to include 'Infection Control Dietary Services: Food Preparation, Service and Cleanliness'. Monitoring: For the next three months (or until 3 months consistent at 100%) the Food Service Director will check the temperature log daily to assure it is being completed correctly; and if it is not will address inconsistencies immediately. The Director of Food Services will submit a weekly compliance report to the CEO regarding temperature logs. The Director of Food Services will report % compliance to the Infection Control Committee on a monthly basis. Goal of 100% compliance. Responsible Person: Director of Food Services, Dietitian, IC Committee, CEO	4.1.15 5.1.15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mona H Choo, CEO | TITLE | (X6) DATE: 4/21/15

State of GA, Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ B. WING _____	04/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 763	Continued From page 1 Review of policy number CRDS4735.OD, last revised 3/31/2014 entitled, "Infection Control Dietary Services: Food Preparation, Service and cleanliness" stipulates inpart, "It is the policy of facility .. that foods be prepared and sevrved in such a manner as to prevent food borne illness and contamination". The Dietary Manager confirmed the findings at the time of discovery.	I 763		
I 789	111-8-68-.07(9) Services- Medical Orders. Medical orders shall be in writing and signed by the physician. Telephone/verbal orders shall be used sparingly and given only to a licensed nurse or otherwise qualified individual as determined by the medical staff in accordance with State law. The individual receiving the telephone/verbal order shall immediately repeat the order and the prescribing physician shall verify that the repeated order is correct. The individual receiving the order shall document, in the patient's clinical record that the order was repeated and verified. Telephone/verbal orders must be signed by the physician within the timeframe designated in the facility 's policies and procedures which ensure that it is done as soon as possible. Where telephone/verbal orders are routinely not being signed within the timeframe designated in the policy, the facility will take appropriate corrective action.	I 789	Corrective Actions: Order books are being created by the Director of Nursing. The night nurse will flag (different color for each physician) and the physician will review and sign every 24 hours or as soon as possible. Orders will be in the book for seven days and then will be removed and filed by the night nurse. Implementation date of May 1, 2015 Education: Director of Performance Improvement will add instruction and competency to new physician orientation by May 30, 2015. Monitoring: The DON will complete random audits and report compliance to PI monthly. Goal of 100% compliance. Responsible Person: Medical Director, Director of Nursing, Director of Performance Improvement	5.1.15 5.30.15

State of GA, Healthcare Facility Regulation Division

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I 789	Continued From page 2 This RULE is not met as evidenced by: Based on record review, observation, and interview the facility failed to insure that the verbal orders were being signed by the physician within twenty-four (24) hours for six (6) of ten (10) sampled patients. Findings include: Record review revealed the following: 1. Record review for patient #1 revealed six (6) order not signed timely. 2. Record review for patient #4 revealed four (4) orders not signed timely. 3. Record review for patient #5 revealed one (1) order not signed timely. 4. Record review for patient #6 revealed four (4) orders not signed timely. 5. Record review for patient #7 revealed ten (10) orders not signed timely. 6. Record review for patient #9 revealed one (1) order not signed timely. Interview on 4-1-2015 with Risk manager confirmed these findings. She states that the physician that signed each order noted is at the facility every day. Review of the policy titled " Seclusion and Physical Hold Restraint " states in part " ...physician ' s written order is entered into the clinical record within 24 hours or as soon as possible ... "	I 789	Corrective Action: Medical Director met with all physicians on April 21, 2015 and directed them to verify seclusion/ restraint orders within 24 hours. A separate seclusion/ restraint order form has been created and will be presented to GOB for approval on April 30, 2015. The order form will go directly to the physician for signature, no longer requiring the Dr. to review every patient record to verify orders. Once approved, the form will be submitted for printing and implemented upon receipt. Target Date of May 30, 2015. 5.30.15 Education: Director of Performance Improvement will meet with current physicians individually to review new process; and will add instructions and competency to new physician orientation by May 30, 2015. 5.30.15 Monitoring: The Risk Manager will complete weekly random audits of seclusion/ restraint order forms and report to Medical Director any instances of non-compliance. Medical Records will complete a monthly audit of seclusion/ restraint forms and report to the PI Committee. Goal of 100% compliance with audits to begin in June. Responsible Persons: Medical Director, Director of Performance Improvement/ RM, Director of Health Information, PI Committee	

State of GA. Healthcare Facility Regulation Division

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	044-588	A. BUILDING: _____ B. WING _____	C 05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	**934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306**

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I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA0060381.	I 000		

State of GA Inspection Report

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State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ B. WING _____	C 07/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	**934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306**

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I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00175500.	I 000		

State of GA Inspection Report

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	044-588	A. BUILDING: _____ B. WING _____	07/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was in substantial compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00153081. The following deficiency was written as the result of that survey.	I 000		
I 763	111-8-68-.07(5) Services- Nutrition. Nutrition. Food services must comply with the Rules and Regulations for Food Service, Chapter 290-5-14. There must be a provision for planning and preparation of special diets as needed. Menus shall be evaluated by a consultant dietitian relative to nutritional adequacy at least monthly, with observation of food intake and changes seen in the patient. This RULE is not met as evidenced by: Based on review of the facility's policies and procedures, facility correspondence, medical record review (#s 1-10) and staff interview, it was determined that the facility failed to follow its policy on the monitoring of patient's weights every month. Findings were: Review of the facility's policy and procedure entitled Vital Signs, Height and Weight, Policy number CRPH4228.0E, revised 07/22/10, revealed that it was the responsibility of the staff nurse to record height and weight one time per month unless more frequent checks were requested by the Doctor or dietician. The policy	I 763		

State of GA. Healthcare Facility Regulation Division

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LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

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I 763	Continued From page 1 stated that height and weight were to be documented on the graphic sheet of the patient's medical record upon admission and monthly. Review of the CDC growth chart and patient #5's graphic sheet revealed that the patient's weight on admission (02/02/15) was #138.8. The patient was not weighed again until 05/22/2015 and his/her weight had dropped to #117. Review of medical records (#s 1-10) revealed that five (5) of ten (10) medical records (#s 1, 2, 4, 5 and 10) failed to have documented evidence that monthly weights were being performed on patients as dictated by the facility's policy. During an interview on 07/29/2015 at 4:15 p.m., the director of clinical services revealed that he/she was unaware that the patient's weights were not being performed and monitored on a monthly basis, but would take measures to remedy the situation right away.	I 763		

State of GA, Healthcare Facility Regulation Division

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	044-588	A. BUILDING _____ B. WING _____	C 08/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

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I 000	Initial Comments. At the time of the survey, Laurel Heights was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA 00153717	I 000		

State of GA Inspection Report

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I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigations # GA00178889.	I 000		

State of GA Inspection Report

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I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was in substantial compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00179764. The following deficiency was cited.	I 000		
I 829 SS=D	111-8-68-.07(12)(a)20 Services- Records. ... Each [clinical] record shall contain at least: ... 20. Recording. Entries in the clinical records shall be made by all staff having pertinent information regarding the patient, consistent with the facility policies, and authors shall fully sign and date each entry. When mental health trainees are involved in patient care, documented evidence shall be in the clinical records to substantiate the active participation of supervisory clinical staff. Symbols and abbreviations shall be used only when they have been approved by the clinical staff and when there is an explanatory legend. Final diagnosis, both psychiatric and physical, shall be recorded in full, and without the use of either symbols or abbreviations. This RULE is not met as evidenced by: Based on interviews, review of medical records, and review of policies and procedures, the facility failed to ensure that the medical record reflected physical assessments, interventions and responses to treatment. Findings included: Review of patient #1's record revealed that on 8/30/17 at 8:30 a.m., a telephone order was given by the nurse practitioner for an	I 829		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 829	Continued From page 1 x-ray of the foot to evaluate foot pain. The x-ray report revealed that on 8/30/17 at 11:30 a.m., an x-ray of the patient #1's foot was taken and there were no abnormalities noted included fractures (breaks). Review of the record did not reveal documentation of the nature of patient #1's foot complaint. In an interview on 10/4/17 at 12:15 p.m. in the conference room, employee #14, a nurse practitioner stated that he/she did not recall patient #1. He/she stated that if a patient had a medical complaint, the unit staff would order a medical consult. He/she stated that a medical consultation form is completed and placed in the medical record after he/she makes an assessment of the patients physical complaint. An interview with employee #2, a therapist, was conducted on 10/3/17 at 3:15 p.m. in the conference room. He/she had been employed at the facility for a year and was the therapist on unit four (4). Employee #2 recalled that patient #1's 'toe' had been hurt by the patient's roommate accidentally slamming it in the door. He/she did not recall the outcome of the injured foot. Employee #2 stated that patient #1 had reported to him/her that another patient had slapped him/her. At the time of the report reported that the patient did not have any visible marks or bruising. Employee #2 did not recall the exact day or date of either of these reported injuries. An interview with employee #5, the program director, was conducted on 10/3/17 at 11:00 a.m. in the conference room. He/she stated that he/she had been in the position since August 1, 2017. He/she recalled that patient #1 had a foot injury but did not recall the exact nature of the	I 829		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ B. WING _____	C 10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	**934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306**

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I 829	Continued From page 2 injury. In an interview on 10/3/17 at 10:00 a.m. in the conference room, employee #2, director of nursing/risk manager, stated that there were no incident reports on record for patient #1. Review of the facility's policy number CRPH4200.0D titled 'Medical Consultation', last reviewed 4/17/17, revealed that medical problems were to be followed up on and treated appropriately through consultations. It was the responsibility of the nurse to notify the patients physician of any medical complaint. The physician was responsible for ordering a medical consultation. A medical consultation form was to be initiated by the nurse and completed by the medical consultant after the patient had been assessed.	I 829		

State of GA. Healthcare Facility Regulation Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	044-588	A. BUILDING: _____ B. WING _____	C 11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	**934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Initial Comments. At the time of the survey, Laurel Heights was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00156477.	I 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Accepted 11/6/2017 DD

		A BUILDING	C
	044-588	B. WING	11/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was not in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00168904. The following deficiency was cited.	I 0000		
I 929 SS=G	111-8-68-.08(2)(c) Emergency Safety Interventions. Emergency safety interventions shall not include the use of any restraint or manual hold that would potentially impair the patient's ability to breathe or has been determined to be inappropriate for use on a particular patient due to a documented medical or psychological condition. This RULE is not met as evidenced by: Based on review of the facility's policies and procedures, medical records (#s 1-10), employee files (#s 1-8), credential files (#s 12 and 13), videotape of the incident, staff and patient interviews, observations and review of facility seclusion and restraint data, it was determined that the facility used a manual hold in a manner that would potentially impair the patient's ability to breathe resulting in the death of the patient. Findings were: Review of the patient #1's medical record revealed that the patient was admitted to this facility for evaluation and treatment of various psychiatric symptoms and problem behaviors.	I 929	RECEIVED DEC 28 2016 HEALTHCARE FACILITY REGULATION DIVISION I 929 **Corrective Action** The DON, Medical Director, and Director of Clinical Services reviewed and revised the policy for Seclusion and Restraint (Policy # CRPM4109.0X) to ensure inclusion of all of the requirements in the rule. The policy was approved by the Governing Body on 12/14/16. The elements of the revised policy include (Tags N-127; 128; 132; 140; 145; 149; 150; 153; 154; 155; 156; 161; and 165) : • An order for restraint or seclusion must not be written as a standing order or on an as-needed basis. • Restraint or seclusion must not result in harm or injury to the resident. • An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).	

PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick McDaniel	COO/Managing Director	01/05/17

(X4) ID TAG	SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID (X5) PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG CROSS-REFERENCED TO THE APPROPRIATE

1929 Continued From page 1

his/her functional behaviors such as coping skills and communication since the time of admission three (3) years previously. Patient #1 was currently in the custody of the Department of Family and Children Services (DFCS).

Review of the Nursing Progress Notes revealed that on the day in question, the nurse was called to assess patient #1 as the patient was aggressive toward a peer as evidenced by patient #1 hitting a peer. Patient #1 required a physical hold/restraints x 2 due to his/her aggressive behavior. The nurse went into the medication room to prepare a medication that was ordered as needed for aggression when a "Code Blue" (an announcement that is used for a cardiopulmonary [heart/lungs] arrest happening to a patient in a hospital or clinic and requiring a team to rush to a location to begin resuscitative efforts) was announced. The nurse ran to the location and found that cardiopulmonary resuscitation (CPR) was being performed on patient #1. 911 was called and CPR was continued until Emergency Medical Technicians (EMTs) arrived and took over the care of patient #1. Review of the Transfer/Emergency Services Progress Note revealed that the patient became unresponsive with no breathing noted and that CPR was initiated. Patient #1 was transferred via ambulance to a local hospital. Efforts to resuscitate patient #1 were unsuccessful and the patient was pronounced deceased by the receiving hospital. An autopsy was pending with a possible diagnosis of aspiration.

Review of patient #1's hold/restraint data revealed that for the previous two (2) months, patient #1 had four (4) holds/restraints-one in September 2016 and three (3) in October 2016 No previous holds/restraints were present for

• Orders for restraint or seclusion must be by a physician, permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician.

• Within 1 hour of the initiation of the emergency safety intervention a physician, or RN trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to

1) The resident's physical and psychological status;

2) The resident's behavior;

3) The appropriateness of the intervention measures; and

4) Any complications resulting from the intervention.

• Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following:

1)Each order for restraint or seclusion as required in paragraph (g) of this section. "As stated in §483.358(g), Each Order for restraint or seclusion must include-" through §483.358(g)(3)"The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use" and associated Guidance.

2)The emergency safety situation that required the resident to be restrained or put in seclusion.

3)The name of staff involved in the emergency safety intervention.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 929	Continued From page 2	I 929		

November 2016. Review of the data from the two (2) holds that occurred on the day in question revealed that no physician orders or documentation of de-escalation attempts were present.

Review of the facility's policy and procedure entitled "Seclusion and Physical Hold/Restraint," Policy # CRPM4109.0W, revised 08/31/16 revealed that it was the policy of the facility to utilize seclusion and physical hold/restraint only as the last resort in the presence of patient behaviors which are imminently threatening the safety of others or the safety of the patient. Less restrictive interventions are attempted as soon as evidence of behavioral and/or verbal escalation occurs. Only when these early interventions fail and/or the patient has escalated so quickly as to be physically out of control is seclusion or physical hold/restraint initiated. These emergency intervention procedures are never to be used as a means of coercion, discipline, retaliation or for the convenience of staff. All seclusion and physical holds/restraints require an initial order from a physician; and if required, an extension from a physician.

Emergency Safety Interventions (ESIs) will be performed in a manner that is safe, proportionate, and appropriate to the severity of the behaviors, and the patient's chronological and developmental age; size, gender, physical, medical and psychiatric conditions and personal history (including any history of physical or sexual abuse). Precautions should be taken to prevent a patient or staff from sustaining a physical or psychological injury during these emergency intervention procedures. Within 1-hour of the initiation of seclusion or physical hold/restraint, the patient's physical and sychological

4) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes.
5) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.
6) Document in the resident's record the date and time the team physician was consulted.
7) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention.

Staff Education

The Director of Nursing, Director of Risk Management, Director of Education, Therapeutic Foster Care, Chief Financial Officer, Director of Admissions, Director of Clinical Services, and Director of Operations or their designees, began re-training all direct care staff, nursing staff, medical staff, and LIPs on revised policy 12/16/16. Completion date is 12/26/16. The following elements were emphasized during the re-education:
• An order for restraint or seclusion must not be written as a standing order or on an as-needed basis.
• Restraint or seclusion must not result in harm or injury to the resident and must be used only
• An emergency safety intervention must be performed in a manner that is safe, proportionate, and appropriate to the severity of the behavior, and the resident's chronological and developmental age; size; gender; physical, medical, and psychiatric condition; and personal history (including any history of physical or sexual abuse).
• Orders for restraint or seclusion must be by a physician, permitted by the State and the facility to order restraint or seclusion and trained in the use of emergency safety interventions. Federal regulations at 42 CFR 441.151 require that inpatient psychiatric services for beneficiaries under age 21 are provided under the direction of a physician.

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1929 Continued From page 3	1929 well-being will be assessed by a physician or licensed professional. The patient's rights, dignity, safety, and well-being will be maintained. 3. Manual Hold/Restrain means the application of physical force, without the use of any device, for the purpose of restricting the free movement of a patient's body. All clinical staff employed at the facility receive training in an approved ESI Course. Staff consistently use these techniques to de-escalate agitated or aggressive patient. Prior to seclusion or physical restraint, all other methods of de-escalation principles and facility practice are used. A refresher training and competency assessment are required twice a year for each clinical employee. Review of the incident video on 11/28/16 at 2:15 p.m. and 11/29/16 at 10:30 a.m. in the Conference Room, revealed that on 11/20/16 at 12:11 p.m. the patient (#1) is noted to be in the hallway just outside of his/her room where a table was observed to have been placed. The patient was noted to struggle physically with a staff member (#2) and the staff member was noted to be straddling the patient by sitting on the patient's midsection at 12:12:33. Another staff member (#3) was noted to be kneeling next to the patient at 12:12:43. At 12:13:33, MHA (#4) was observed approaching the two staff members and the patient. At 12:14:40 the MHA (#2) was seen getting off the patient. Continued review of the video revealed the MHA (#4) was noted to be on the patient's back with the patient facing the ground at 12:17:23. The patient was noted to be struggling, and the MHA was seen holding the patient's arms above his/her head. The MHA was observed to continue struggling with the patient while the patient remained face down until		• Within 1 hour of the initiation of the emergency safety intervention a physician, or RN trained in the use of emergency safety interventions and permitted by the state and the facility to assess the physical and psychological wellbeing of residents, must conduct a face-to-face assessment of the physical and psychological wellbeing of the resident, including but not limited to 1) The resident's physical and psychological status; 2) The resident's behavior; 3) The appropriateness of the intervention measures; and 4) Any complications resulting from the intervention. • Staff must document the intervention in the resident's record. That documentation must be completed by the end of the shift in which the intervention occurs. If the intervention does not end during the shift in which it began, documentation must be completed during the shift in which it ends. Documentation must include all of the following: 1) Each order for restraint or seclusion as required in paragraph (g) of this section. "As stated in §483.358(g), Each Order for restraint or seclusion must include-" through §483.358(g)(3)"The emergency safety intervention ordered, including the length of time for which the physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion authorized its use" and associated Guidance. 2) The emergency safety situation that required the resident to be restrained or put in seclusion. 3) The name of staff involved in the emergency safety intervention. 4) The facility must maintain a record of each emergency safety situation, the interventions used, and their outcomes. 5) The physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion must sign the restraint or seclusion order in the resident's record as soon as possible.	

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I929	Continued From page 4 I929 12:20:01 when the MHA was observed turning the patient over. The patient appeared to be unconscious. The MHA appeared to be yelling and staff was noted to be running in the video. The NP (#13) and RN (#7) were observed running into the day room at 12:20:45. CPR was initiated at 12:21:03. The AED arrived and was placed on the patient at 12:24:10. EMS arrived at 12:36:47, and the patient was transported out the day room by EMS at 12:45:15. During an interview with Director of Recreation Therapy (DRT, Employee #1) and Mind Set Instructor on 11/28/16 at 3:11 p.m. in the Conference Room, the DRT revealed that he/she was a certified Mindset Program (a physical restraint program used in crisis prevention) Instructor. The DRT stated that he/she provides the staff with training for physical restraint holds and methods of de-escalation used in the facility. The DRT stated that the correct way to administer a horizontal was to have no less than two (2) staff members administering the hold. The DRT further stated that t the patient's breathing, airway, and circulation were to be monitored at all times while the patient is in a hold. The DRT stated that the patient was to be placed laterally (on his/her side) while on the ground or floor. The DRT stated that holding a patient in a face-down position was contraindicated as it could cause undue pressure to the chest and abdomen and restrict respirations. The DRT stated that if a patient verbalized or indicated in any way that they were having difficulty breathing, the staff member was to release the patient immediately. The DRT also stated that there would never be a situation that would justify a patient being held facedown and straddled. The DRT further stated that all staff receive a two (2) day, fourteen (14) hour full course on physical		6) Document in the resident's record the date and time the team physician was consulted. 7) Clinical staff trained in the use of emergency safety interventions must be physically present, continually assessing, and monitoring the physical and psychological well-being of the resident and the safe use of restraint throughout the duration of the emergency safety intervention **Monitoring** 100% of restraint/seclusion documents are monitored by the Director of Risk or designee to ensure that all elements are correctly completed within 24 hours. Any variation in practice will result in additional training and/or disciplinary action up to and including termination. Aggregate data is reported monthly to the Quality Council and Medical Executive Committee monthly and Governing Board quarterly. **Responsible Persons** Director of Nursing; Risk Manager; CEO; Director of Clinical Services; Director of Operations; Medical Director **I 929** **Corrective Action** All facility staff were re-educated on Critical Guidelines for Physical Intervention, which included a review of communication skills, protective skills, and therapeutic holds. The review provided Mindset Handbook of Visual Depictions of Appropriate Technique of Physical Restraint, as well as, included the following: 1)Use Communication first. Communication is the first and least restrictive approach towards preventing aggression. 2) Only use a physical restraint or hold as a last resort when the child is: a. Harming themselves b. Harming someone else c. There is a high probability of harm if not physically prevented	

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I 929	Continued From page 5			

holds and de-escalation. and that all employees received a six (6) month refresher course that was approximately four and a half (4.5) hours. The ORT stated that a six (6) hour annual training is also given. The ORT added that the testing included a demonstration and a written test, and if any staff member needed further instruction or practice, it was always offered during the courses.

During the course of the interview, the ORT was asked to view the video of the incident for the first time, which the ORT agreed to do. The following portion of the interview was conducted after the viewing of the interview.
When asked if the MHA (#2) should have straddled the patient with his/her weight, the ORT stated that placing his/her weight on the patient was not appropriate. When asked why the ORT explained that placing weight on the patient in that way could constrict the patient's breathing and cause undue injury to the patient. The ORT added that the MHA should never have approached the patient alone, and the MHA
should have asked for assistance. When asked if MHA (#4) was holding the patient correcting while administering a horizontal hold, the MHA indicated the hold was not done correctly or appropriately. When asked why the ORT stated the MHA should have never been on the patient's back. When asked why the ORT indicated the weight of the MHA could cause undue injury to the patient and restrict breathing. The ORT stated that the staff has been taught to release the patient if the hold cannot be applied correctly.
The DRT added that the staff members who were observing and assisting the hold should have alerted the MHA that the hold was not being handled correctly.
During an interview with the Director of Nursing

3) Whenever possible, avoid going to the floor with a child and never use a horizontal restraint without assistance: Going to the floor without assistance increases the probability of injury for staff and the child.
4) Never intentionally inflict harm and/pain onto a child-avoid using paint o maintain a restraint.
a. Any use of pain or joint pressure can result in physical and psychological injury to the child and will reduce trust. It teaches that it is acceptable to inflict pain to get results.
5) Communicate to the child that you are trying to keep them safe.
6) Never place a towel, blanket, or other covering over a child's head during a hold. It can interfere with breathing.
7) Never lie on top of a child & avoid provocative body positions: putting your weight on a child can constrict breathing and it can re-traumatize. Never hold a child between the legs or have any type of genital contact.
8) Never hold a child's head still during a physical restraint. The cervical spine can be injured.
9) Never place your elbow, knee, or foot onto any part of a child's body when holding them on the floor. Never rest your entire body weight on a child when trying to contain them on the floor.
10) During a physical restraint, always monitor the child's:
a. Circulation or skin color
b. Respiration or breathing
c. Any other signs of physical distress

*If there is physical distress...ADJUST or RELEASE THE HOLD

11) Do not lecture, threaten, or try to discipline a child during a physical restraint.
12) Avoid engaging in general conversation with co-workers during a physical restraint; the focus should be on helping the child regain control

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I929	Continued From page 6	I929		

(DON) (#11) on 11/29/16 at 1:55 p.m. in the Conference Room, the DON revealed that the first time the patient (#1) was restrained at approximately 12:11 p.m. on 11/20/16, no MD order for the restraint was obtained due to the ongoing situation with the patient. The DON stated that after second restraint hold in the day room, the RN (#7) was trying to get a medication to administer to the patient, and a code blue was called. The DON stated that subsequently, an order for the restraint was never obtained.

During an interview with the MD (#14) on 11/29/16 at 2:10 p.m. in the Conference Room, the MD stated he/she was informed about the restraint after the incident, but the MD stated he/she had never been called about obtaining an order for the restraint. The MD explained that orders that needed to be signed were placed in his/her box. When asked if the MD had received any paperwork regarding the restraint for the patient on 11/20/16, the MD stated he/she had not.

Review of the videotape and interview with the Mindset instructor (employee #1) during the viewing of the videotape revealed that the holds/restraints on the day in question with patient #1 were done incorrectly. The facility was unable to tell the surveyors how often or even if the videos of the milieu were reviewed on a regular basis in order to assure that the holds/restraints performed by the staff were done properly. Review of the employee files revealed that all employees involved in the incident had received hold/restraint training according to the facility's policy, but the facility failed to monitor whether staff were performing those holds/restraints according to their Mindset training.

Staff Education

Unit 7 direct care staff were re-educated by Certified Mindset Instructors on the management of aggressive behavior techniques including the review of communication skills, protective skills, and therapeutic holds, as well as, verbal de-escalation. Mindset Skills Assessments were re-issued. Unit 7 retraining was completed as of 12/7/16

100% of active facility staff has been re-educated on the Critical Guidelines for Physical Intervention, as well as, provided Mindset Handbook of Visual Depictions of Appropriate Technique of Physical Restraint as of 12/16/16.

Monitoring

Certified Emergency Safety Intervention Instructors or designee will review 100% of physical holds that are viewable on surveillance camera to review correct use of trained techniques. Staff identified as not meeting standards for correct technique will be provided additional training in individual or group settings. Ongoing non-compliance will be addressed through disciplinary action up to and including termination. Aggregate data is reported monthly to the Quality Council, Medical Executive Committee and quarterly to the Governing Body.

Responsible Persons

Director of Nursing; Risk Manager; Director of Clinical Services; Director of Operations;
Certified Emergency Safety Intervention Instructors

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11L005	A. BUILDING _____ B. WING _____	C 11/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAUREL HEIGHTS HOSPITAL	934 BRIARCLIFF ROAD, NE ATLANTA, GA 30306

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 000	Initial Comments At the time of the survey, Laurel Heights Hospital was not in compliance with Condition of Participation 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Impatient Psychiatric Services for Individuals Under Age 21 as a result of the investigation of complaint #GA00168904. This noncompliance caused serious harm to one (1) of ten (10) identified sampled patients. On 11/28/16 at 2:45 p.m., an immediate jeopardy (IJ) situation was identified. The Leadership Team consisting of the Chief Operating Officer (CEO), the Director of Clinical Services (DCS), the Director of Human Resources (DHR), the Medical Director (MD), the Director of Operations (DOO), and a representative of UHS Corporation were informed of this IJ on 11/28/16 at 4:15 p.m. On 11/29/16 at 10:15 a.m., an Organization Plan of Action and Risk Reduction Strategies was presented to the surveyors. The Plan consisted of the following: Action Item #1 Progressive discipline actions for identified staff directly involved in the incident will be taken to include written counseling up to termination as determined appropriate pending the completion of the investigation. Evidence of progressive discipline will be maintained in personnel files. Completion date; 11/29/16. Update: One (1) of the three (3) employees involved in the incident was terminated on 11/29/16. The other two (2) staff remain on	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/10/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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N 000	Continued From page 1 suspension pending results of the investigation. Action Item #2 Direct care staff will be re-educated on the facility protocols in conducting appropriate and adequate observation rounds including timely observations, accurate documentation, and hand-off communication. Re-education has been initiated on 11/21/16 and to be completed by 12/02/16. Staff performance will be monitored through the senior leadership and observation round audits will be conducted in person and camera review at a minimum of once per shift per unit per week. 11/29/16 Update: In process. The Director of Operations (DOO) continues to provide education and obtain verbal counseling checklist (attached). Staff will be re-trained on conducting appropriate and adequate observation rounds including timely observations, accurate documentation, and hand-off communication. Re-education will be conducted during each shift change meeting that is overseen by DOO or designee. Will develop and utilize immediate counseling form for Leadership Team and others to use when doing Leadership Rounds. This will give immediate feedback to the employee and require a signature that the employee has been re-educated. The form will then be turned into HR/Manager to determine the appropriate action to address. Date to complete all actions: 12/12/16. Action Item #3 Direct care staff will be re-educated on the facility protocols regarding staff dress codes and the presence of personal cell phones. Re-education has been imitated on 11/21/16 and is to be completed by 12/02/16. Staff compliance will be	N 000		

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monitored through the senior leadership and observation round audits will be conducted in person and camera review at a minimum of once per shift per unit per week.
11/29/16 Update: In process. DOO continues to provide education and obtain verbal counseling checklist (attached). Reviewed and provided a copy of Dress Code ((MHR9015.0D) and Guidelines for Professional Conduct. Professional Conduct Policy will be adopted and approved by Medical Executive Committee and trained to all employees by 12/12/16.

Action Item #4
Automated External Defibrillators (AED) machine will be re-located to Unit 7. Nursing and direct care staff will be re-educated on the locations of emergency medical equipment including the AED machine to be completed by 12/02/16.

Update 11/19/16: AED machines were relocated to provide access to all staff on 11/23/16. Education with staff began on 11/23/16 and is on track by 12/12/16. Attestations will be housed in HR file.

Action Item #5
Nursing and direct care staff will be re-educated on the facility protocols regarding notification, response and staff roles for psychiatric and medical codes. Competencies will be documented and maintained in the personnel files. Re-education to be completed by 12/02/16.
Update 11/19/16: Two nurses per shift have been assigned to respond to code Blues including bringing AED and Emergency bag. Leadership Team will review and update Code 10 and Code Blue Policies to include evaluation of individual

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competencies for direct care employees. Will include a schedule of monthly Code Blue drills and quarterly Code Ten drills and scenarios. Will review and update policy in PI 11/30/16. Educate Staff on updated policies by 12/12/16.

Action Item #6
Unit 7 direct care staff will be re-educated on the management of aggressive behavior techniques including Mindset and Verbal De-escalation by 12/16/16. Revised date of completion 12/02/16.
11/28/16: Critical Guidelines for Physical Intervention were reviewed with all staff on duty and oncoming shifts, email
11/30/16 Update: All direct care staff will be re-educated on the management of aggressive behavior techniques and Verbal De-escalation by 01/31/17.

Action Item #7
A Performance Improvement Team on the facility policies and practice regarding restraint and seclusion will be established by 11/30/16. Team members will include the identified senior leaders and direct care staff.
11/19/16 Update: Meeting is scheduled with an array of team members from different departments for 11/30/16.

Action Item #8
Staff will be re-educated regarding the prohibition of parking personal vehicles in identified fire lanes. Re-education to be completed by 12/02/16.
11/19/16: Email blast sent to all employees. Announce in shift change report. Identified plant operations and Leadership Team to enforce non-compliance.

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N 000	Continued From page 4 Action Item #9 Complete a thorough investigation into reported phone issues regarding access and dropped calls from Unit 7. 11/19/16 Update: Completed. Verified that we have adequate capacity to manage all incoming and outgoing phone calls. Action Item #10 All staff will be re-educated on the Critical Guidelines for Physical Intervention as well as provided Mindset Handbook of Visual Depictions of Appropriate Technique of Physical Restraint. Documentation will be maintained in personnel files by 12/02/16, Update: This process was started 11/28/16. The IJ was removed on 11/29/16 at 10:15 a.m.	N 000		
N 100	USE OF RESTRAINT AND SECLUSION CFR(s): 483.354 Subpart G: Condition of Participation for the Use of Restraint and Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age Twenty One. This CONDITION is not met as evidenced by: Based on review of the facility's policies and procedures, medical records (#s 1-10), employee files (#s 1-8), credential files (#s 12 and 13), videotape of the incident, staff and patient interviews, observations and review of facility seclusion and restraint data, it was determined that the facility failed to ensure the safety of a patient during a restraint, resulting in the death of the patient. A Condition was cited at N-0100 and	N 100		

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N 100	Continued From page 5 an Immediate Jeopardy (IJ) was called on 11/28/16 at 4:15 p.m. The facility provided an acceptable Credible Allegation of Compliance on 11/29/16 at 10:15 a.m. Tags N-127, N-128, N-132, N-140, N-145, N-149, N-150, N-153, N-154, N-155, N-156, N-161 and N-165 resulted in the Condition non-compliance to be made. Findings were: Review of the patient #1's medical record revealed that the patient was admitted to this facility for evaluation and treatment of various psychiatric symptoms and problem behaviors. Patient #1 was currently receiving intensive behavior therapy and multiple efforts to increase his/her functional behaviors such as coping skills and communication since the time of admission three (3) years previously. Patient #1 was currently in the custody of the Department of Family and Children Services (DFCS). Review of the Nursing Progress Notes revealed that on the day in question, the nurse was called to assess patient #1 as the patient was aggressive toward a peer as evidenced by patient #1 hitting a peer. Patient #1 required a physical hold/restraints x 2 due to his/her aggressive behavior. The nurse went into the medication room to prepare a medication that was ordered as needed for aggression when a "Code Blue" (an announcement that is used for a cardiopulmonary [heart/lungs] arrest happening to a patient in a hospital or clinic and requiring a team to rush to a location to begin resuscitative efforts) was announced. The nurse ran to the location and found that cardiopulmonary resuscitation (CPR)	N 100		

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N 100	Continued From page 6	N 100		

was being performed on patient #1. 911 was called and CPR was continued until Emergency Medical Technicians (EMTs) arrived and took over the care of patient #1. Review of the Transfer/Emergency Services Progress Note revealed that the patient became unresponsive with no breathing noted and that CPR was initiated. Patient #1 was transferred via ambulance to a local hospital. Efforts to resuscitate patient #1 were unsuccessful and the patient was pronounced deceased by the receiving hospital. An autopsy was pending with a possible diagnosis of aspiration.

Review of patient #1's hold/restraint data revealed that for the previous two (2) months, patient #1 had four (4) holds/restraints-one in September 2016 and three (3) in October 2016 No previous holds/restraints were present for November 2016. Review of the data from the two (2) holds that occurred on the day in question revealed that no physician orders or documentation of de-escalation attempts were present.

Review of the facility's policy and procedure entitled "Seclusion and Physical Hold/Restraint," Policy # CRPM4109.0W, revised 08/31/16 revealed that it was the policy of the facility to utilize seclusion and physical hold/restraint only as the last resort in the presence of patient behaviors which are imminently threatening the safety of others or the safety of the patient. Less restrictive interventions are attempted as soon as evidence of behavioral and/or verbal escalation occurs. Only when these early interventions fail and/or the patient has escalated so quickly as to be physically out of control is seclusion or physical hold/restraint initiated. These emergency

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intervention procedures are never to be used as a means of coercion, discipline, retaliation or for the convenience of staff. All seclusion and physical holds/restraints require an initial order from a physician; and if required, an extension from a physician.

Emergency Safety Interventions (ESIs) will be performed in a manner that is safe, proportionate, and appropriate to the severity of the behaviors, and the patient's chronological and developmental age; size, gender, physical, medical and psychiatric conditions and personal history (including any history of physical or sexual abuse). Precautions should be taken to prevent a patient or staff from sustaining a physical or psychological injury during these emergency intervention procedures. Within 1-hour of the initiation of seclusion or physical hold/restraint, the patient's physical and psychological well-being will be assessed by a physician or licensed professional. The patient's rights, dignity, safety, and well-being will be maintained. 3. Manual Hold/Restrain means the application of physical force, without the use of any device, for the purpose of restricting the free movement of a patient's body.

All clinical staff employed at the facility receive training in an approved ESI Course. Staff consistently use these techniques to de-escalate agitated or aggressive patient. Prior to seclusion or physical restraint, all other methods of de-escalation principles and facility practice are used. A refresher training and competency assessment are required twice a year for each clinical employee.

Review of the incident video on 11/28/16 at 2:15

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N 100	Continued From page 8 p.m. and 11/29/16 at 10:30 a.m. in the Conference Room, revealed that on 11/20/16 at 12:11 p.m. the patient (#1) is noted to be in the hallway just outside of his/her room where a table was observed to have been placed. The patient was noted to struggle physically with a staff member (#2) and the staff member was noted to be straddling the patient by sitting on the patient's midsection at 12:12:33. Another staff member (#3) was noted to be kneeling next to the patient at 12:12:43. At 12:13:33, MHA (#4) was observed approaching the two staff members and the patient. At 12:14:40 the MHA (#2) was seen getting off the patient. Continued review of the video revealed the MHA (#4) was noted to be on the patient's back with the patient facing the ground at 12:17:23. The patient was noted to be struggling, and the MHA was seen holding the patient's arms above his/her head. The MHA was observed to continue struggling with the patient while the patient remained face down until 12:20:01 when the MHA was observed turning the patient over. The patient appeared to be unconscious. The MHA appeared to be yelling and staff was noted to be running in the video. The NP (#13) and RN (#7) were observed running into the day room at 12:20:45. CPR was initiated at 12:21:03. The AED arrived and was placed on the patient at 12:24:10. EMS arrived at 12:36:47, and the patient was transported out the day room by EMS at 12:45:15. During an interview with Director of Recreation Therapy (DRT, Employee #1) and Mind Set Instructor on 11/28/16 at 3:11 p.m. in the Conference Room, the DRT revealed that he/she was a certified MindSet Program (a physical restraint program used in crisis prevention)	N 100		

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Instructor. The DRT stated that he/she provides the staff with training for physical restraint holds and methods of de-escalation used in the facility. The DRT stated that the correct way to administer a horizontal was to have no less than two (2) staff members administering the hold. The DRT further stated that t the patient's breathing, airway, and circulation were to be monitored at all times while the patient is in a hold. The DRT stated that the patient was to be placed laterally (on his/her side) while on the ground or floor. The DRT stated that holding a patient in a face-down position was contraindicated as it could cause undue pressure to the chest and abdomen and restrict respirations. The DRT stated that if a patient verbalized or indicated in any way that they were having difficulty breathing, the staff member was to release the patient immediately. The DRT also stated that there would never be a situation that would justify a patient being held facedown and straddled. The DRT further stated that all staff receive a two (2) day, fourteen (14) hour full course on physical holds and de-escalation. and that all employees received a six (6) month refresher course that was approximately four and a half (4.5) hours. The DRT stated that a six (6) hour annual training is also given. The DRT added that the testing included a demonstration and a written test, and if any staff member needed further instruction or practice, it was always offered during the courses.

During the course of the interview, the DRT was asked to view the video of the incident for the first time, which the DRT agreed to do. The following portion of the interview was conducted after the viewing of the interview.

When asked if the MHA (#2) should have

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straddled the patient with his/her weight, the DRT stated that placing his/her weight on the patient was not appropriate. When asked why the DRT explained that placing weight on the patient in that way could constrict the patient's breathing and cause undue injury to the patient. The DRT added that the MHA should never have approached the patient alone, and the MHA should have asked for assistance. When asked if MHA (#4) was holding the patient correcting while administering a horizontal hold, the MHA indicated the hold was not done correctly or appropriately. When asked why the DRT stated the MHA should have never been on the patient's back. When asked why the DRT indicated the weight of the MHA could cause undue injury to the patient and restrict breathing. The DRT stated that the staff has been taught to release the patient if the hold cannot be applied correctly. The DRT added that the staff members who were observing and assisting the hold should have alerted the MHA that the hold was not being handled correctly.
During an interview with the Director of Nursing (DON) (#11) on 11/29/16 at 1:55 p.m. in the Conference Room, the DON revealed that the first time the patient (#1) was restrained at approximately 12:11 p.m. on 11/20/16, no MD order for the restraint was obtained due to the ongoing situation with the patient. The DON stated that after second restraint hold in the day room, the RN (#7) was trying to get a medication to administer to the patient, and a code blue was called. The DON stated that subsequently, an order for the restraint was never obtained.
During an interview with the MD (#14) on 11/29/16 at 2:10 p.m. in the Conference Room, the MD stated he/she was informed about the restraint after the incident, but the MD stated he/she had

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N 100	Continued From page 11 never been called about obtaining an order for the restraint. The MD explained that orders that needed to be signed were placed in his/her box. When asked if the MD had received any paperwork regarding the restraint for the patient on 11/20/16, the MD stated he/she had not. Review of the videotape and interview with the Mindset instructor (employee #1) during the viewing of the videotape revealed that the holds/restraints on the day in question with patient #1 were done incorrectly. The facility was unable to tell the surveyors how often or even if the videos of the milieu were reviewed on a regular basis in order to assure that the holds/restraints performed by the staff were done properly. Review of the employee files revealed that all employees involved in the incident had received hold/restraint training according to the facility's policy, but the facility failed to monitor whether staff were performing those holds/restraints according to their Mindset training.	N 100		

State of GA. Healthcare Facility Regulation Division

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I 000	Initial Comments. At the time of the survey, Laurel Heights Hospital was in compliance with Chapter 111-8-68 Rules and Regulations for Residential Mental Health Facilities for Children and Youth, as a result of complaint investigation #GA00182161.	I 000		

State of GA Inspection Report

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE